NaphCare

Referral to Mental Health

Inmate Name:	ID #:	Location:	DOB:
Inman, John	[redacted]	CCS	[redacted]

Reason for Referral

- ○ *Crisis Intervention*
  - ○ Family problems: _____
  - ○ Problems with peers: _____
  - ○ Recent stress: _____
  - ○ Other: _____
- ○ *Evaluation of Mental Condition*
  - ○ Suicidal
  - ○ Homicidal
  - ○ Mutilative
  - ○ Hostile, angry
  - ○ Other inappropriate behavior
  - ○ Anxious
  - ○ Depressed
  - ○ Withdrawn
  - ○ Poor hygiene
  - ○ Physical complaints
  - ○ Sleep disturbance
  - ○ Hallucinations/delusions
  - ○ Suspicious
  - ○ Impassivity
  - ○ Grandiosity
  - ○ Hyperactivity
- ○ *Evaluation of Need for Psychiatric Intervention*
- ○ *History of Psychotropic Medication prior to Intake*
- ☒ *Other*

Comments: Refusing to eat - See next 2 pages

Referred by: _____ Department: _____ Date: _____

Mental Health Follow-up: Evaluation / Treatment / Disposition

S: Pt refusing to eat. Take meds 2° not getting his demands he moving, housing... "I have to pull up c the idiots here I don't had no pride."

O: Pt c multiple c/o's not getting to sleep where he wants while he's in jail... not want "noise" would like a private, quiet, sleeping premises — + calmy making demands. Threatening "it's gonna be bad..." if I get his own ways

A: Antisocial issues

P: 1. D/c Trazodone - pt says it works 2) D/c Elavil - plays & wit 3) F/u 1-3 mos

Follow-up by: M. Elizabeth Lachman, md Date: 5/16/04 Time: 500p.

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: INMAN, JOHN 234821

Date of Birth: [redacted] Social Security No.:

Date: 5/26/05 Time: 9 45 A.M. P.M.

This is to certify that I, INMAN, JOHN (Print Inmate's Name), currently in custody at the FRANK LEE (Print Facility's Name), am refusing to accept the following treatment/recommendations: Refuse to have prostate + colon screening (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

John Inman (Signature of Inmate)**

D. Haywood (Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 5-23-05

To: Frank Lee

From: Natalie PA / Staton Health Care

Inmate Name: Inman, John **ID#:** 234821

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other BBP - Bottom Bunk Profile

Comments:

Date: 5-23-05 **MD Signature:** Dr. Williams / per Natalie PA **Time:** 11:40am

60418

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 11/05/04

To: Draper Corr. Center

From: SICW

Inmate Name: Inman, John **ID#:** 234821

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

X-Ray on 11/08/04

Date: 11/05/04 **MD Signature:** L. Lasseter ARNP / D. Austin 4pd **Time:** _____

60418

Prison Health Services
Treatment Record

Treatment Ordered:

Dsg/Splint ∆ ② finger

Date	Date	Date	Date	Date	Date	Date
11/1/04						
TD Dom						
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Comments:

Patient Name/Number	Allergies:	Housing Unit:
234821 Ingram, John	NKA	Dorm 5

Baptist Health
ER RECORD - Adult / Adolescent

B0430200570 INMAN,JOHN D
DOB: [redacted] Age:46Y MR #:569296
Admit Date/Time: 10/28/04 1558P
916 SHAW,RONALD A
Patient Label IN TRIAGE, OUTPT

Regular M.D.: _____ Notified: _____
Immunization Hx: Tetanus ☐ UTD ☐ not UTD 3yrs ago
Allergies: NKDA
LMP: _____ Pregnant? ☐ Yes ☐ No ☐ Unsure
Home Meds: NONE

TRIAGE CATEGORY
1) RED - Immediate 2) YELLOW - Urgent 3) GREEN - 0 Non-Urgent

Vital Signs
BP 118/82
P 70
R 24
T 97.7
SPO2 98

CHIEF COMPLAINT AND HISTORY
☐ See T Sheet "C/O shoulde pain, back of neck & bilateral knees. C/O pain in finger "split. may be broken"

Analgesia Scale IVAS 0-10 8 /10 0 (no pain) 10 (worst)

AGE SPECIFIC CARE
13-18 yrs (Adolescent)
(Menarche started? ☐ Yes ☐ No Age at onset?_____ Regular ☐ Yes ☐ No)
>65 yrs (Older Adult)
Assisting Devices: ☐ None ☐ Yes (list): _____
Living arrangements: ☐ Lives alone ☐ Family/Significant Others ☐ Extended Care Facility

GENERAL APPEARANCE & MENTAL STATUS

General	Skin Temp	Respiration	Pulse	Mental Status
☐ NAD	☑ Warm	☑ Unlabored	☑ Regular	☑ Alert
☐ Mild Distress	☐ Hot	☐ Clear Bilat.	☐ Irregular	☑ Oriented
☐ Acute Distress	☐ Cool	☐ Shallow	☐ Bounding	☐ Age Appropriate
	☐ Cold	☐ Labored	☐ Weak	☐ Anxious
Skin Color	**Skin Moisture**	☐ Wheezes	☐ Absent	☐ Combative
☑ Pink	☐ Dry	☐ Crackles	**Neuro Status**	☐ Unresponsive
☐ Flushed	☐ Diaphoretic	☐ Apneic	☑ Normal	☐ Tearful
☐ Pale	**Gait**	☐ Retraction	☐ Slurred Speech	☐ Confused
☐ Ashen	☐ Steady	☐ Nasal Flaring	☐ Weakness L/R	☐ Agitated
☐ Cyanotic	☐ Unsteady	☐ Stridor		☐ Disoriented
☐ Jaundiced	Visual Acuity: O.S.:_____	O.D.:_____	O.U.:_____	

PLAN OF CARE

Problems
☑ Anxiety/Fear ☐ Body Temp, Alt. In ☐ Comm. Alt. In ☐ Coping Alt. In ☐ Elimination Alt. In ☐ Fluid Vol., Def/Ex ☐ Infection Potential ☐ Domestic Violence ☐ Abuse Potential (refer to Social Services) ☐ Pain ☐ Nutrition (refer to Dietitian) ☐ Knowledge Deficit ☐ Neuro Status ☐ Physical Mobility Impairment ☐ Resp. Function Alt. ☐ Skin Integrity, Alt. In ☐ Cultural/Religion ☐ Language

Intervention
☐ Anti-Puretic ☐ Bleeding Control ☐ DSG/Wound Care ☐ Emotional support ☐ Ice/elevate ☐ I & O ☐ Other_____ ☐ Sling/Splint ☐ Teaching ☐ Labs ☐ X-Ray ☐ Meds As Ordered ☐ O2

☐ Social Services ☐ Animal Control ☐ DHR Referral ☐ Police Notified_____ ☐ PT ☐ Dietitian ☐ Coroner

Weight:_____ stated / measured

Triage Nurse Signature: M Johnson RN Date 10/28 Time _____

Time To Tx Area: Rm #

NURSE'S NOTES
(1940) IV DC'd & cath intact

Pt in spinal package & C collar

PHYSICIAN'S ASSESSMENT

ORDERS
LNT (1620) 20g (R) AC x1stick aseptic tech plus1ws — mvn
(1840) suture set up @ BS

VITAL SIGNS

Time			
B.P.			
Temp.			
Pulse			
Resp.			
O2 Sat.			

LAB
☐ CBC ☐ Cardiac ☐ Urinalysis ☐ Liver Profile ☐ Amylase ☐ Chem Profile 7 ☐ Chem Profile 12 ☐ Mej Trauma ☐ Min Trauma ☐ EKG ☐ ETOH ☐ ABG ☐ UCG ☐ I-Stat ☐ _____ ☐ Lipase ☐ PT/PTT

X-RAY
☐ Chest ☐ Portable ☐ Ct _____ #/# ☐ Abd ☐ _____

DISCHARGE
Date 10/28 Time 1917
D. C'd RN M Johnson RN

Medications	Dose	Route	Time	Site	Nurse
ANCEF	1gm	IV	1623	mvn	
Tdap needed					

Certified Medical Emergency ☐ YES ☐ NO
Diagnosis: ☐ See T Sheet
Index finger
Carpal strain

DISPOSITION
☐ Home ☐ Admit ☐ Surgery ☐ Transfer ☐ EXP ☐ AMA ☐ LWT ☐ SNF ☐ Other ☐ M.D. Office

EXIT VIA
☐ Walk ☐ Carried ☐ WC ☐ Stretcher ☐ Ambulance

ACCOM. BY
☐ Self ☐ Fam/Friend ☐ PcRce ☐ Other

Condition on Discharge

Physician Signature: Ronald Shaw, MD

PRINTED BY: b17606 DATE 10/29/2004

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23b

Baptist Health

EMERGENCY PHYSICIAN RECORD
Laceration Procedure Notes

B0430200570 INMAN,JOHN D
DOB: [redacted] Age:46Y MR #:569296
Admit Date/Time: 10/28/04 1558P
916 SHAW,RONALD A

Wound Description #1

Wound: FINGER

Size: 2 -cm

Distal NVT:
✓ sensation intact ✓ vascular intact __ tendon intact
UNABLE TO EXTEND

Depth / shape / contamination:
✓ superficial __ linear __ *irregular __ *flap
✓ SQ __ nail avulsed __ *stellate
__ muscle __ contused tissue
✓ clean
__ contaminated minimally / moderately / *heavily
with dirt gravel grease ink _____

ANESTHESIA
✓ local LET / TAC __ digital block _____ cc
__ lidoc 1% 2% epi / bicarb __ marcaine .25% .5%

WOUND PREP AND REPAIR
✓ Hibiclens / Betadine
__ betadine to skin
✓ wound cleanser
✓ irrigated / washed w/ saline
moderate / *extensive
__ wound explored
__ foreign material removed
partially completely
minimal / mod. / *extensive
__ debrided
minimal / *mod. / *extensive
__ undermined
minimal / mod. / *extensive

Wound closed with: wound adhesive / steri-strips _____

SKIN
3 X 5 -0 nylon / prolene / vicryl / staples _____
__ interrupted __ running ✓ simple __ mattress (h / v)

***SUBCUTANEOUS / MUCOSA**
2 X 4 -0 vicryl / silk _____
__ interrupted __ running __ simple ✓ mattress (h / v)

***FASCIA / MUSCLE / TENDON** _____
#____ ____-0 vicryl / _____
__ interrupted __ running __ simple __ mattress (h / v)

NAIL / NAIL MATRIX
__ nail excised __ nail reattached #____ ____-0 vicryl / _____

***OTHER**
__ retention suture placed

Wound Description #2

Wound: _____

Size: _____ -cm

Distal NVT:
__ sensation intact __ vascular intact __ tendon intact

Depth / shape / contamination:
__ superficial __ linear __ *irregular __ *flap
__ SQ __ nail avulsed __ *stellate
__ muscle __ contused tissue
__ clean
__ contaminated minimally / moderately / *heavily
with dirt gravel grease ink _____

ANESTHESIA
__ local __ LET / TAC __ digital block _____ cc
__ lidoc 1% 2% epi / bicarb __ marcaine .25% .5%

WOUND PREP AND REPAIR
__ Hibiclens / Betadine
__ betadine to skin
__ wound cleanser
__ irrigated / washed w/ saline
moderate / *extensive
__ wound explored
__ foreign material removed
partially completely
minimal / mod. / *extensive
__ debrided
minimal / *mod. / *extensive
__ undermined
minimal / mod. / *extensive

Wound closed with: wound adhesive / steri-strips _____

SKIN
#____ ____-0 nylon / prolene / vicryl / staples _____
__ interrupted __ running __ simple __ mattress (h / v)

***SUBCUTANEOUS / MUCOSA**
#____ ____-0 vicryl / silk _____
__ interrupted __ running __ simple __ mattress (h / v)

***FASCIA / MUSCLE / TENDON** _____
#____ ____-0 vicryl / _____
__ interrupted __ running __ simple __ mattress (h / v)

NAIL / NAIL MATRIX
__ nail excised __ nail reattached #____ ____-0 vicryl / _____

***OTHER**
__ retention suture placed

*may indicate intermediate repair. *may indicate intermediate or complex repair.
Repair of muscles or tendons in complex wounds is reported with appropriate separate repair codes.

x _____ MD / DO (Resident) x _____ MD / DO (Attending)

☒ I've reviewed, Patient interviewed, Medical Decision Making, and Examined by Physician.

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17

Baptist Health

EMERGENCY PHYSICIAN RECORD

MVA (5)

B0430200570 INMAN,JOHN D
DOB: [redacted] Age:46Y MR #:569296
Admit Date/Time: 10/28/04 1558P
916 SHAW,RONALD A

DATE: 10/28 TIME: 1600 ROOM: BH-4 __ EMS Arrival
HISTORIAN: __patient __spouse __paramedics
__HX / __EXAM UNOBTAINABLE 2° TO:

HPI chief complaint: (MVA) Injury to: BODY

occurred: __just PTA

position in vehicle: driver (passenger) front (back)

context: (MVA)-car collision overturned vehicle
single-car accident (lost control / fell asleep / unknown cause)
IN BUS, (L) SIDE, 2 WAY BACK

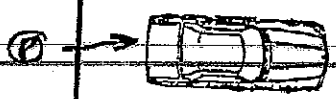
location of pain / injuries:
head face mouth
(neck) chest
gastrointestinal
back upper mid- lower
radiating to (R / L) thigh / leg

-right-		-left-	
shldr	hip	(shldr)	hip
arm	thigh	arm	thigh
elbow	(knee)	elbow	(knee)
f-arm	leg	f-arm	leg
wrist	ankle	wrist	ankle
hand	foot	(hand)	foot

severity of pain:
(mild)
moderate
severe

associated symptoms:
__lost consciousness / dazed
duration:
remembers:
(before) (coming to hospital)
__seizure

site of impact:
"P" = primary "S" = secondary



force (low) mod. high
direct glancing

restraints:
(none) lap / shoulder
doesn't recall
car seat
air bag deployed
thrown from vehicle
ambulated at scene
long extrication

PAST HX (negative)
__HTN __DM

Meds: __none / __see nurses note
Allergies: __NKDA / __see nurses note

SOCIAL HX __recent ETOH (smoker) __drug abuse PRISONER
FAMILY HX HTN

__HX / __EXAM UNOBTAINABLE 2° TO:

ROS (all systems neg except as mkd)

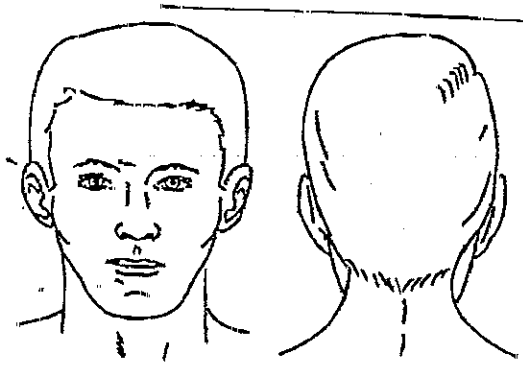
NEURO
__loss feeling / power arms/legs
__headache
EYES
__double vision
ENT
__hearing loss
RESPIRATORY
__trouble breathing
CVS
__chest pain
GI
__nausea / vomiting
GU
__loss of bladder function
SKIN
__skin laceration
CONST
__recent fever / illness

☐ Nursing Assessment Reviewed ☑ Vitals Reviewed ☐ Tetanus Immun, UTD

PHYSICAL EXAM (Alert) __Lethargic __Anxious
Distress: __NAD (mild) __moderate __severe
Other: (c-collar (PTA / in ED)) (back board) __IV __splint

HEAD
(no evidence of trauma)
__see diagram
__Battle's sign / Raccoon Eyes

NECK
__non-tender
__painless ROM
__trachea midline
__see diagram
__vertebral point-tenderness
__muscle spasm / decreased ROM
__pain on movement of neck



EYES
(PERRL)
(EOMI)
__unequal pupils R-___mm L-___mm
__EOM entrapment / palsy
__subconjunctival hemorrhage

ENT
__nml external inspection
__no dental injury
__hemotympanum
__TM obscured by wax
__closed nasal blood
__dental injury / malocclusion

RESP / CVS
__chest non-tender
__breath sounds nml
__heart sounds nml
__see diagram (on reverse)
__decreased breath sounds
__wheezing / rales
__splinting / paradoxical movements

GASTROINTESTINAL
__non-tender
__no organomegaly
__see diagram (on reverse)
__tenderness / guarding / rebound
__mass / organomegaly

GENITAL / RECTAL
__nml genital exam
__nml vaginal exam
__nml rectal exam
__heme negative stool
__perineal hematoma
__blood at urethral meatus
__decreased rectal tone

NEURO / PSYCH
(oriented x3)
(mood & affect)
__CN's nml as tested
__sensation & motor nml
__confusion / disorientation
__EOM palsy / anisocoria
__facial asymmetry
__unsteady / ataxic gait
__sensory / motor deficit

Patient

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DATE: 10/29/2004 HISTORY x _____ RN / PA / NP MD
RN / PA / NP sign after recording history; physician initial after reviewing with patient and confirming or revising

SKIN
- intact
- warm, dry

BACK
- no CVA tenderness
- no vertebral tenderness

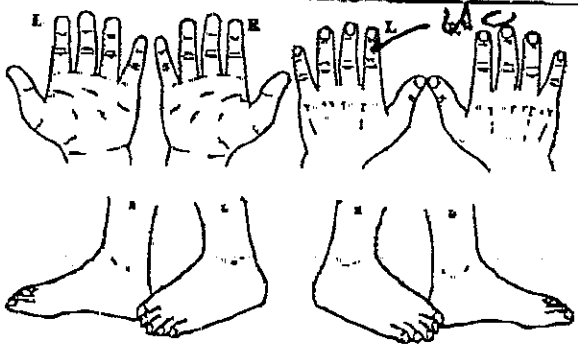
EXTREMITIES
- atraumatic
- pelvis stable
- hips non-tender
- no pedal edema
- nml ROM

__see diagram
__crepitus / diaphoresis

__see diagram
__vertebral point-tenderness
__CVA tenderness
__muscle spasm / limited ROM

__see diagram
__bony point-tenderness Hand
__painful / unable to bear weight
__pulse deficit

Joint Exam:
__limited ROM / ligamentous laxity / joint effusion



XRAYS ☐ Interp. by me ☐ Reviewed by me ☑ Discsd w/ radiologist

C-Spine D-Spine LS-Spine
- nml / NAD
- no fracture
- nml alignment
- soft tissues nml

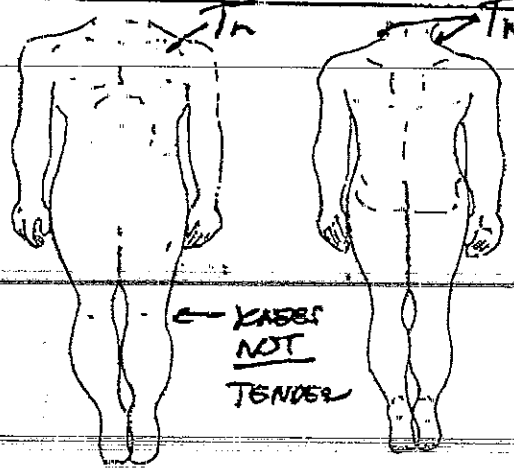
__reversal / straightening of cerv. lordosis
__DJD / spondylosis / spurring

CXR
- nml / NAD
- no infiltrates
- nml heart size
- nml mediastinum

__rib fracture
__infiltrate / atelectasis
FINGER - TUFT FX

OTHER ☐ See separate report

CT SCAN
__normal



Tr=Tenderness
PtTr=Point Tenderness
S=Swelling
E=Ecchymosis
Lac=Laceration
A=Abrasion B=Burn
(☐ without ☐ mild ☐ moderate ☐ severe)
Trv= Tenderness on palpation (severe)

LABS and PROGRESS

CBC (normal except)	Chemistries (normal except)		
WBC	BUN	CO2	
Hgb	Creat	Ca	
Hct	Gluc	Bilirubin	
Platelets	Alk Phos	Magnesium	
segs	Cl	BNP	
bands	ALT	D-Dimer	
lymphs	AST		
monos	Na		
eos	K		

Re-evaluation time ____ __unchanged __improved __re-examined
Re-evaluation time ____ __unchanged __improved __re-examined
Re-evaluation time ____ __unchanged __improved __re-examined

NO KNEE ROM LIMITATION
NO FLUID THERE
W+U FLUID FINGER, SHOULDER NECK

FLUID- TUFT FX
SUSPECT TENDON (MALLET FINGER)
PLAN SUTURE
SPLINT
ORTHO FOLLOWUP

__use template #23b for Laceration Repair

TREATMENT:
- Fluids IV
- Analgesics PO IM IV
- Antibiotics PO IM IV

MEDICAL DECISION:

Fracture Care: Follow up with orthopedic within 48 hours
__Rx given
__Follow up with ORTHO

__Discussed with Dr. _____
will see patient in office / ED / hospital
__Counseled patient / family regarding:
lab results diagnosis need for follow-up
__Admit orders written

__CRIT CARE- 30-74 min ____ min
75-104 min
Prior records ordered
__Additional history from:
family caretaker paramedics

CLINICAL IMPRESSION: MVA

contusion		injury	
head		wrist	R / L
face		hand	R / L
chest		hip	R / L
Gastrointestinal		thigh	R / L
back		knee	R / L
shoulder	R / L	leg	R / L
arm	R / L	ankle	R / L
elbow	R / L	foot	R / L
forearm	R / L		

sprain / strain
neck dorsal lumbar sacral

concussion
with LOC w/o LOC

laceration

LAC FINGER
TUFT FX

DISPOSITION ☐ home ☐ admitted ☐ transferred
CONDITION ☐ unchanged ☑ improved ☐ stable

x _____ MD / DO x _____ MD / DO
Resident Attending

☐ Hx review, Patient interviewed, Medical Decision Making and Examined by Physician.

PRINTED BY: b17606 DATE 10/29/2004
10/29/2004 FRI 11:14 [TX/RX NO 5154] 027

AERAS Physicians

%

804302005570 INMAN,JOHN D
DOB: [redacted] Age:46Y MR #:569296
Admit Date/Time: 10/29/04 1558P
916 SHAW,RONALD A

TEST	SYMPTOMS		
Urinalysis CC Cath	Abdominal Pain Diabetes Dysuria Edema Fever	Flank Pain Hematuria Hesitancy Hypertension Known Kidney Disease	Long Term Medications Nocturia Pelvic Pain Trauma to Kidney/Urinary Tract Other_____
Chest X-ray Portable Regular	Abnormal Sputum Abnormal Weight Loss Abnormal X-ray Chest Pain Clubbing of Fingers Coma	Cough Cyanosis Fever Hemoptysis Palpitations	Respiratory Infection Respiratory Distress Shock Other_____
CT of Head With contrast Without Contrast	Closed Head Injury (Concussion) CVA/TIA Delirium/Dementia Headache (excluding Migraine) Penetrating Trauma	Occlusion of Artery Seizure Sinusitis (Chronic) Stroke Subarachnoid/Intracerebral Hemorrhage	Suspected Metastasis Syncope/Collapse Other_____
CT Abdomen/Pelvis Oral IV	Abdominal Pain Abdominal Rigidity Abdominal Swelling Abdominal Tenderness Aneurysm Ascites	Blunt/Penetrating Trauma Edema Extravasation of Urine Fever Hepatomegaly/Splenomegaly Injury to Blood Vessels	Infection, Post OP Internal Injury (Thorax, Abd. & Pelvis) Liver Disease Renal Colic Other_____
Abd. Ultrasound	Abdominal Pain Abdominal Mass Abdominal Tenderness Abnormal X-ray Ascites Abdominal Swelling	Colic Flank Mass Flank Pain Flank Tenderness Hepatomegaly/Splenomegaly	Pelvic Pain Pelvic Mass Pelvic Tenderness Spleen Mass Other_____
EKG	Abnormal Electrocardiogram Arrhythmia Cardiac Arrest Chest Pain Dizziness Dyspnea	High Risk Medication(s) Hypertension Hx. HTN Hx. Renal Disease Hx. Valvular Disease Palpitations	Respiratory Insufficiency Shock Syncope/Collapse Tachycardia Other_____

Other Test(s):	Symptom(s):
(R) L) WRIST	TRAUMA
C-SPINE	"
L) SHOULDER	"

Physician's Signature: _____ Date: _____

NP/PA Signature: _____ Nurse Signature: _____

Proprietary: AERAS/Prime Care
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Baptist Health
Emergency Room
Discharge Instructions

B0430200570 INMAN,JOHN D
DOB: [redacted] Age:46Y MR #:569296
Admit Date/Time: 10/28/04 1558P
916 SHAW,RONALD A

DISCHARGE INSTRUCTIONS – PATIENT COPY

Weight	Phone	Allergies

MEDICINES PRESCRIBED | If non, check this box: ☐ | **VOID IF NOT PRINTED WITH CRANBERRY BACKGROUND.** | Location: South

	Name/Strength	Number	Schedule / Duration	No Refills	Refills
1.	Cefzil 500	10	1 po bid	☐	
2.	Lortab 7.5	12	1-2 po q4-6h prn pain	☑	
3.				☐	
4.				☐	
5.				☐	

INSTRUCTION SHEET(S) GIVEN

☐ Asthma ☐ Back Pain ☐ Cast / Splint Care ☐ Crutches ☐ Fever ☐ Fracture ☐ Head Injury ☐ Otitis Media ☐ Sprains / Bruises ☑ STD ☐ Threatened Ab ☐ Vomiting / Diarrhea ☐ Wound Care ☐ Other(s)

Return for signs of infection
> Redness
> Swelling
> Drainage
> Heat

Additional Instructions:

Referred to:
☑ Dr. Lindsey
Phone: _____
☑ Call on next business day for follow-up appointment in _____ days / weeks ☐ next available

☐ Return to Emergency Dept. in _____ hours / days for recheck
☐ If no improvement or your condition worsens, call your private physician or return to the Emergency Department for a recheck.
☐ Learning needs assessed ☐ Instructions Modified: _____
☐ Education provided on new medication _____

I understand that the treatment I have received was rendered on an emergency basis and is not meant to replace complete care from a primary care provider or clinic. Furthermore, I may have been released before all of my medical problems were apparent, diagnosed, and/or treated. If my condition worsens, I have been instructed to call my primary care provider or return to this facility or the nearest emergency center. I understand that I should NOT drive or perform hazardous tasks if my medication or treatment causes drowsiness. I have read and understand the above, received a copy of this form and applicable instruction sheets, and I will arrange for follow-up care. If diagnostic tests indicate a need for modification in therapy, you will be notified at the phone number you provided.

☐ Patient ☐ Relative ☐ Other _____

Instructed By: MJohnson RN

Time Released > 1917 Hrs.

Physician: [signature]

WORK/ SCHOOL STATEMENT from the Emergency Department

Patient Name _____ Date _____

☐ Patient was seen by Dr.
☐ No athletics / physical education: _____ days*
☐ May return to work / school without restrictions
☐ Will require time off work / school. Estimated time: _____ days*
☐ Must be reevaluated by family / occupational physician before returning to school / work.
☐ May return to restricted duties for _____ days*
Restrictions: _____
☐ _____ was here with relative/ child.
☐ Other: _____

Time off from School or Work longer than stated must be approved by a Personal or Company/ Occupational Medicine Physician, unless otherwise stated.

ENTERED BY: 517605 DATE 10/29/2004

01 10/28/04
0430200570 10/28/04 1558P M [redacted] 46Y 1 S O E/R ER E/R / 569296

INMAN, JOHN D 421-92-3995
P O BOX 1107 (334)567-1548
STATON PRISON ELMORE NOT EMPLOYED
ELMORE AL 36025

FACILITY, STATON CORRECTIONAL 02/29/76 128Y
PO BOX 1107
STATON CORRECTIONAL FACIL (334)567-1548 NOT EMPLOYED
ELMORE AL 36025 TRUST OFFICE

FACILITY, STATON CORRECTIONAL 02/29/76 128Y
PO BOX 1107
STATON CORRECTIONAL FACIL (334)567-1548 NOT EMPLOYED
ELMORE AL 36025 TRUST OFFICER

PRISON HEALTH SERVICES FACILITY, STATON CORRECTIONAL

AIS 234821 STATON PRISON INMATE

(800)729-0069 CLAIMS DEPT

105 WESTPARK DR #200 BRENTWOOD TN 37027

719.41-JOINT PAIN-SHLDER U %

AUTO/MOTORIZED VEH PT WAS IN MVA 10/28/04 1512P

HAYNES AMBULANCE

---

916 SHAW, RONALD A 916 SHAW, RONALD A

01 10/28/04

EMERGENCY 1

ED

RE7 10/28/04 YES
DEFAULT, PHYSICIAN SHAW, RONALD A
PRINTED BY: b17606 DATE 10/29/2004

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 10/29/04

To: Draper

From: HCU

Inmate Name: Inmon, John **ID#:** 234821

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments: House of Left hand x 14 days

Date: 10/29/04 **MD Signature:** [signature] **Time:** _____

60418

☐ SOUTH 286-2
☐ EAST 244-8
☐ PRATTVILLE 361-4

PRESCRIPTION FOR

B0430200570 INMAN,JOHN D
DOB: [redacted] Age:46Y MR #:569296
Admit Date/Time: 10/28/04 1558P
916 SHAW,RONALD A

Baptist Health

Emergency Room Prescription Form

Weight	Phone	Allergies	Location
			South

MEDICINES PRESCRIBED | If non, check this box: ☐ | **VOID IF NOT PRINTED WITH CRANBERRY BACKGROUND**

	Name/Strength	Number	Schedule / Duration	No Refills	Refills
1.	Percocet 5/325	10	÷ 3/0	☑	
2.	Lortab 7.5	18	÷ 96h pm pain	☑	
3.				☐	
4.				☐	
5.				☐	

Emillo Belaval
AL 22654
DEA - BB5295248

David G. Alexander
DO - 657
AA3259226

Victoria L. Beckman
DEA - BB62553885
AL - 22440

Joel Sullivan
DEA - AS2020066
ARN - 10094

John Moorehouse
DEA - AM6869119
ARN - 7151

Steven G. O'Mara
DEA - BO1736074
DO - 713

Ronald A. Shaw
AL - 6388
DEA - AS5646813

Jessie Austin
DEA - AA8394075
ARN - 8595

Brad Frisbie
DEA - BF2524583
ARN - 15396

Julio Enrico Rios
ARN - 21678
DEA - BR2471326

Tom Decaro
DEA - AD2628355
ARN - 11369

Thomas Arnold
DEA - AA9548655
ARN - 16275

Wallace Falero
AL - 9405
DEA - AF1692119

Henry Kurusz III
DEA - AK2572116
AL - 22198

Paul Tanaka
ARN - 7153
DEA - 8922-898

James M. Bradwell
DEA - BB6422086
AL - 22767

Label all prescriptions
No refills

Product Selection Permitted _____ M.D./D.O.

Dispense as Written _____ M.D./D.O.

BSB:0082 (06/02)

%

B0430200570 INMAN,JOHN D
DOB: [redacted] Age:46Y MR #:569296
Admit Date/Time: 10/28/04 1558P
916 SHAW,RONALD A

Baptist Health
Emergency Room Discharge Instructions

DISCHARGE INSTRUCTIONS – MEDICAL CHART

Weight	Phone	Allergies	Location South

MEDICINES PRESCRIBED If non, check this box: ☐ **VOID IF NOT PRINTED WITH CRANBERRY BACKGROUND**

Name/Strength	Number	Schedule / Duration	No Refills	Refills
1.			☐	
2.			☐	
3.			☐	
4.			☐	
5.			☐	

INSTRUCTION SHEET(S) GIVEN

☐ Asthma ☐ Back Pain ☐ Cast / Splint Care ☐ Crutches ☐ Fever ☐ Fracture ☐ Head Injury ☐ Otitis Media ☐ Sprains / Bruises ☐ STD ☐ Threatened Ab ☐ Vomiting / Diarrhea ☐ Wound Care ☐ Other(s)_____

Return for signs of infection
> Redness
> Swelling
> Drainage
> Heat

Additional Instructions:

Referred to:
☐ Dr. _____
Phone: _____
☑ Call on next business day for follow-up appointment
in _____ days / weeks ☐ next available

☐ Return to Emergency Dept. in _____ hours / days for recheck
☐ If no improvement or your condition worsens, call your private physician or return to the Emergency Department for a recheck.
☐ Learning needs assessed ☐ Instructions Modified: _____
☐ Education provided on new medication _____

I understand that the treatment I have received was rendered on an emergency basis and is not meant to replace complete care from a primary care provider or clinic. Furthermore, I may have been released before all of my medical problems were apparent, diagnosed, and/or treated. If my condition worsens, I have been instructed to call my primary care provider or return to this facility or the nearest emergency center. I understand that I should NOT drive or perform hazardous tasks if my medication or treatment causes drowsiness. I have read and understand the above, received a copy of this form and applicable instruction sheets, and I will arrange for follow-up care. If diagnostic tests indicate a need for modification in therapy, you will be notified at the phone number you provided.

X _____ ☐ Patient ☐ Relative ☐ Other_____

Time Released > 1917 Hrs

Instructed By: MJohnson RN Physician: _____

WORK/ SCHOOL STATEMENT from the Emergency Department

Patient Name _____ Date _____

☐ Patient was seen by Dr.
☐ No athletics / physical education: _____ days*
☐ May return to work / school without restrictions
☐ Will require time off work / school. Estimated time: _____ days*
☐ Must be reevaluated by family / occupational physician before returning to school / work.

☐ May return to restricted duties for _____ days*
Restrictions: _____
☐ _____ was here with relative/ child.
☐ Other: _____

Time off from School or Work longer than 3 days should be approved by a Personal or Company/ Occupational Medicine Physician unless otherwise stated

PRISON HEALTH SERVICES INCORPORATED

MEDICAL INFORMATION TRANSFER FORM

Confidential Medical Data

To: Baptist South (Agency)

(Address) Montg AL

From: Draper Inst. (Institution)

Elmore, AL (Address)

( ) 3671548 (Telephone)

Inmate's Name: Duncan John

a/k/a:

D.O.B: [redacted] SS #:

Person Completing Form

Name: M. Barrett

Signature: M Barrett

Date: 10.28.04

MEDICAL PROBLEM(S):

Neck Pain c (L) shoulder injury

HepC +

TREATMENTS/MEDICATIONS:

Evaluate & Treat

Allergies: NKDA

Pregnant: Yes No Unknown

Other Lab Data:

TB Skin Test: (NEG) POS Date 5.27.04

CXR: NEG POS Date

Test			Treated	Date
RPR:	NEG	POS	Yes No	
VDRL:	NEG	POS	Yes No	
GC:	NEG	POS	Yes No	
Other:			Yes No	

60109 (4/87)

WHITE - RECEIVING INSTITUTION, YELLOW - MEDICAL FILE

PHS
PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSION DATE	TIME	ORIGINATING FACILITY	
10 / 28 / 04	2p (AM) PM	☐ SIR ☐ PDL ☐ ESCAPEE ☐ Draper pop	☐ SICK CALL ☑ EMERGENCY ☑ OUTPATIENT

ALLERGIES: NKA

CONDITION ON ADMISSION: ☐ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

VITAL SIGNS: TEMP 98.4 (ORAL) RECTAL RESP 20 PULSE 88 B/P 140, 90 RECHECK IF SYSTOLIC <100> 50 ___ / ___

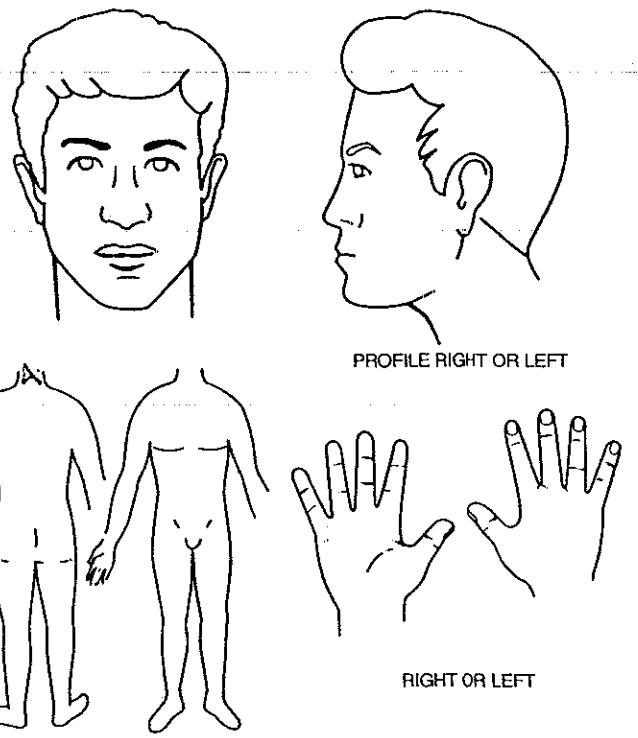
NATURE OF INJURY OR ILLNESS

5-11 My shoulder, finger, collar bone & back of my neck.

A Hep C

145 / 96 22 98.6 90

ABRASION ///	CONTUSION #	BURN xx xx	FRACTURE Z Z	LACERATION / ___ SUTURES



PHYSICAL EXAMINATION

O - Ambulated into ER pers. Co pain to (L) index finger, (L) Collar bone, back of neck. ROM to (L) shoulder limited. Co pain trying to flex neck from side to side.

A - MVA

P - Transfer to Baptist South ER

ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY

DIAGNOSIS: MVA

INSTRUCTIONS TO PATIENT

DISCHARGE DATE	TIME	RELEASE / TRANSFERRED TO	CONDITION ON DISCHARGE
10 / 28 / 04	AM PM	☐ DOC ☐ AMBULANCE ☐	☐ SATISFACTORY ☐ POOR ☐ FAIR ☐ CRITICAL

NURSE'S SIGNATURE	DATE	PHYSICIAN'S SIGNATURE	DATE	CONSULTATION
K Austin LPN	10/28/04			

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC
Inman, John	234921	[redacted]	WM	Draper

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 7/27/04

To: Staton

From: Draper

Inmate Name: FUMAN, JOHN **ID#:** 234821

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:
Request Lay In X One Day

Date: 7/27/04 **MD Signature:** _____ **Time:** _____

60418

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 06/17/04

To: Draper Corr. Center

From: Staton Health Care Unit

Inmate Name: Inman, John **ID#:** 234821

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Bottom Bunk Profile x 1 year

Date: 06/17/04 **MD Signature:** D. McArthur RS/D Austin Lpn **Time:** 905A

60418

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Loomis John

LAST **FIRST** **MI**

DATE OF BIRTH [redacted] **SS#** 423 18 21

Housing Recommendations:

General Population ✓

Medical Observation Unit ____

Lower Level/Lower Bunk ?

Suicide Precautions ✓

Special Watch (15 Minute Checks) ____

Isolation ____

Initiate Universal Precautions ____

Individual found to be:

Frail/Elderly ✓

~~Physically Handicapped~~ ____

Developmentally Disabled ____

Drug/Alcohol Withdrawal ____

Special Mental Health Needs ✓

Expressed Suicidal Ideation ____

History of Seizures ____

Other ____

Specify ____

Nurse [signature] Date 1/15/04

GLF 1005 Original/Classification Second Copy/Booking Staff Third Copy/Medical Unit

Draper Correctional Facility:

Sick call is performed at 5:00 am in the pill call room Monday through Friday. All completed sick call requests and grievances must be placed in the locked sick call request box located beside the pill call window. All sick call requests must be completed and turned at evening pill call.

Pill call for general population is performed three times a day from the pill call room located beside the shift office at the times stated below. Pill call is subject to change by health care unit and security.

1. Morning pill call: 6:00 am (Directly after sick call)
2. Noon pill call: 11:00 am
3. Evening pill call: 5:30 pm

Segregation pill call is performed at the above times directly after the general population pill call.

Any dental, medical, or mental health educational information can be obtained through a written request to the Health Services Administrator.

I have had the opportunity to ask questions concerning the above information, and I have received a copy.

Inmate Signature: _____ Date: 6-16-04

Nurse Signature: _____ Date: 6/15/04

N610

ALABAMA DEPARTMENT OF CORRECTIONS

RECEIVING SCREENING FORM

Inmate's Name: John Inman 234821 Date: 6/14/04 Time: 8:32a

DOB [redacted] Officer: C Jones Institution: DCC

Booking Officer's Visual Opinion

	Yes	No
1. Is the inmate conscious?	✓	
2. Does the inmate have any obvious pain or bleeding/other symptoms suggesting the need for emergency services?		✓
3. Are there any visible signs of trauma or illness requiring immediate emergency treatment or doctor's care?		✓
4. Any obvious fever, swollen lymph nodes, jaundice, or other evidence of infection which might spread through the institution?		✓
5. Is the skin in poor condition or show signs of vermin or rashes?		✓
6. Does the inmate appear to be under the influence of alcohol or drugs?		✓
7. Are there any visible signs of alcohol or drug withdrawl? (extreme perspiration, shakes, nausea, pinpoint pupils, etc.)		✓
8. Is the inmate making any verbal threats to staff or other inmates?		✓
9. Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?	✓	
10. Does the inmate have any obvious physical handicaps?		✓

If the answer is YES to any questions from 2-10 above, specify WHY in section below

11. Are you presently taking medication for diabetes, heart disease, seizure, arthritis, asthma, ulcers, high blood pressure or psychiatric disorder?	✓	
12. Are you on any special diet prescribed by a physician? (if YES, what type?)		✓
13. Do you have a history of venereal disease or abnormal discharge?		✓
14. Have you recently been hospitalized or recently seen a medical or psychiatric doctor for any illness?	✓	
15. Have you ever attempted suicide?		✓

(If YES, When? _____ How? _____

16. Do you want to do any harm to yourself now?		✓

PHS
PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSION DATE 6/10/04 TIME 10:10 AM (PM)
ORIGINATING FACILITY ☐ SIR ☐ PDL ☐ ESCAPEE ☐ _____
☐ SICK CALL ☐ EMERGENCY ☐ OUTPATIENT

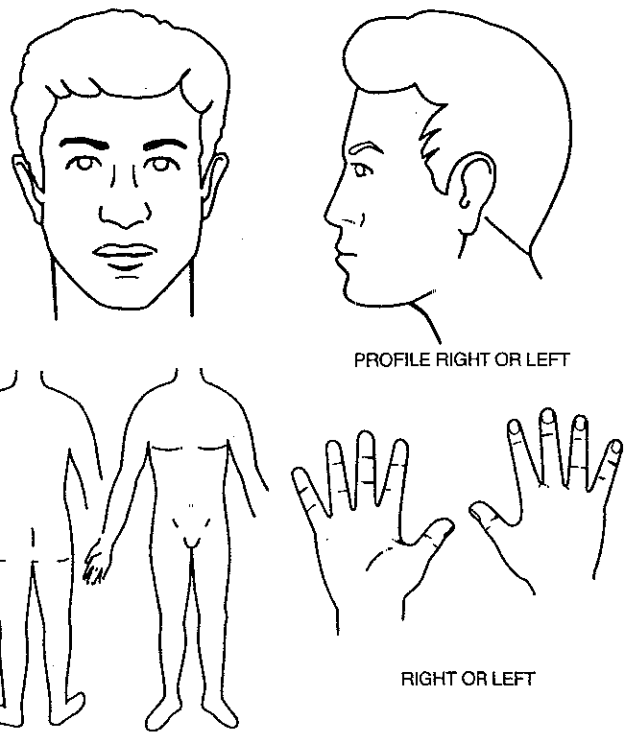
ALLERGIES NKA
CONDITION ON ADMISSION ☐ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

VITAL SIGNS: TEMP 99.1 (ORAL) RECTAL RESP 22 PULSE 94 B/P 128/80 RECHECK IF SYSTOLIC <100> 50 ____/____

NATURE OF INJURY OR ILLNESS *Body Chart per D.O.C

S- "I was jumped on tonight!" I blocked the hit with my arm and his fist hit my arm."

ABRASION /// CONTUSION # BURN xx xx FRACTURE Z Z LACERATION / ____ SUTURES



PHYSICAL EXAMINATION

O- Noted slight redness to (L) forearm & elbow noted active R.O.M. No open or raised areas noted

A- Injury to (L) AKA

P- Return to D.O.C

ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY

DIAGNOSIS

INSTRUCTIONS TO PATIENT More

DISCHARGE DATE 6/10/04 TIME 10:20 AM (PM) RELEASED/TRANSFERRED TO ☒ DOC ☐ AMBULENCE ☐ _____
CONDITION ON DISCHARGE ☒ SATISFACTORY ☐ FAIR ☐ POOR ☐ CRITICAL

NURSE'S SIGNATURE Carolyn D. Harrell RN DATE 6/10/04 PHYSICIAN'S SIGNATURE (R) 6/11/04 DATE CONSULTATION

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Inman, John	234821	[redacted]	W M	KCF

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 6/4/04

To: _____

From: _____

Inmate Name: Inman, John **ID#:** 234821

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

① No prolonged standing, walking (> 30 min) x 90 days

② No heavy lifting (> 10 lb) x 90 days

Date: 6/4/04 **MD Signature:** _____ **Time:** _____

60418

RECEIVING SCREENING FORM

INMATE'S NAME: Inman John DATE: 5/24/04 TIME: 10:45 AM

DOB: [redacted] OFFICER: Freddie McCampbell INSTITUTION: KILBY

RECEIVING OFFICER'S VISUAL OPINION

	YES	NO
Is the inmate conscious?	X	
Does the inmate have any obvious pain or bleeding or other symptoms suggesting the need for doctor's care?		X
Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care?		X
Any obvious fever, jaundice, or other evidence of infection which might spread through the institution?		X
Is the skin in poor condition or show signs of vermin or rashes?		X
Does the inmate appear to be under the influence of alcohol, or drugs?		X
Are there any signs of alcohol or drug withdrawal? (Extreme perspiration, shakes, nausea, pinpoint pupils, etc.)		X
Is the inmate making any verbal threats to staff or other inmates?		X
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?		X
Does the inmate have any obvious physical handicaps?		X

Hepatitis C

FOR THE OFFICER

Was the new inmate oriented on sick/dental call procedures?

This inmate was

X a. Released for normal processing

____ b. Referred to health care unit

____ c. Immediately sent to the health care unit.

Freddie McCampbell

Officer's Signature

This form will be completed at receiving and will be filed in the inmate's medical jacket to comply with NCCH Standards.

PHS
PRISON HEALTH SERVICES INCORPORATED

INCORPORATED

faxed 5-25-04 mh

Authorization for Release of Information

To: Dr Scarborough
Florence, Al
256 760-9095

From: KCF - Physicals Dept.
215-6698 (F)
215-6691 (O)

Patient: Inman, John

Inmate ID No.: 234821

Alias:

Social Security No: [redacted]

Date of Birth: [redacted]

Date(s) of Service:

I hereby authorize the above named provider to release to Prison Health Services, Inc. or any of its representatives the following confidential information:

[✓] Physician/Provider's summary of my diagnosis, medications, treatments, prognosis and recent care

[ ] Admission [ ] Discharge [ ] Operative Summary Reports

[ ] X-Ray [ ] Special Studies Reports [ ] HIV Test [ ] T B Test

[✓] Laboratory Reports [ ] Immunization History [ ] Dental Treatment Records

[ ] Psychiatric Summary Report [ ] Substance Abuse Treatment History & Counseling Reports

[✓] Other Records Hepatitis C
(Specify information requested)

This authorization shall remain in full force and effect until withdrawn in writing by me. I hereby release and agree to hold provider harmless from any and all liability that may result from such release of information.

X John Inman
(Patient's Signature)

5-25-04
(Date)

Rhonda Hardy, HPA
(Witness Signature)

5-25-04
(Date)

The information requested is recognized as confidential and will be used only to ensure prompt and appropriate treatment of the named patient.

(Signature and Title for PHS)

(Date)

****
*** TX REPORT ***
****

TRANSMISSION OK

JOB NO.	1353
DESTINATION ADDRESS	
PSWD/SUBADDRESS	
DESTINATION ID	
ST. TIME	05/25 13:54
USAGE T	00'47
PGS.	2
RESULT	OK

FAX COVER SHEET

DR JOHN W. SCARBOROUGH
101 WEST COLLEGE ST SUITE C
FLORENCE, AL 35634

PHONE (256) 760-9003
FAX ~~(256) 767-3808~~ 256-760-9095

SEND TO	
Company name: Ms. Hardy, LPN -	From: Dr Scarbrough
Attention: Tuscon Health Service	Date: 5-27-04
Office location:	Office location:
Fax number: 334-215-6698	Phone number: 256-760-9003

☐ Urgent ☐ Reply ASAP ☐ Please comment ☐ Please review ☐ For your information

Total pages, including cover: [redacted]

COMMENTS

John Summer
SD # 234821
DOB [redacted]

PHS
PRISON HEALTH SERVICES
INCORPORATED

faxed 5-25-04 mh

Authorization for Release of Information

To: Dr Scarborough
Florence, AL
256 760-9095

From: KCF - Physicals Dept.
215-6698 (F)
215-6691 (O)

Patient: Inman, John

Inmate ID No.: 234821

Alias:

Social Security No: [redacted]

Date of Birth: [redacted]

Date(s) of Service:

I hereby authorize the above named provider to release to Prison Health Services, Inc. or any of its representatives the following confidential information:

[ ] Physician/Provider's summary of my diagnosis, medications, treatments, prognosis and recent care

[ ] Admission [ ] Discharge [ ] Operative Summary Reports

[ ] X-Ray [ ] Special Studies Reports [ ] HIV Test [ ] T B Test

[ ] Laboratory Reports [ ] Immunization History [ ] Dental Treatment Records

[ ] Psychiatric Summary Report [ ] Substance Abuse Treatment History & Counseling Reports

[ ] Other Records Hepatitis C
(Specify information requested)

This authorization shall remain in full force and effect until withdrawn in writing by me. I hereby release and agree to hold provider harmless from any and all liability that may result from such release of information.

X John Inman
(Patient's Signature)

5-25-04
(Date)

Wanda Hardy HPA
(Witness Signature)

5-25-04
(Date)

The information requested is recognized as confidential and will be used only to ensure prompt and appropriate treatment of the named patient.

(Signature and Title for PHS) (Date)

60102 (11/02)

INMAN, JOHN
Chief Complaint: Follow Up Visit
01 Apr 2004

HISTORY / PHYSICAL EXAMINATION

Chief Complaint: Mangement of chronic problems and medications
Present Illness: The patient is a 45 year old male who presents for a follow-up visit.
He has a chronic history of **anxiety** which is well-controlled. He has a chronic history of **hepatitis** which is well-controlled. He has a chronic history **of lumbar disc disease** which is well-controlled.

REVIEW OF SYSTEMS:

Constitutional: Patient denies any fever, chills, or generalized weakness.
Cardiovascular: No varicose veins, high blood pressure, or chest pain.
Respiratory: No wheezing, frequent coughing, or shortness of breath.
Musculoskeletal: **Back pain,** pain radiating down right LE
Psychologic: **Anxious, Depressed**

SOCIAL HISTORY: Does not use alcoholic beverages
Daily Tobacco Use:
Cigarette Packs/day= 1

ALLERGIES: None

Physical Examination:

Constitutional: vital signs: **pulse rate - 84, systolic BP** - 140, **diastolic BP - 90, temperature (F) -** 100.1, **weight** - 177; mental status - alert and oriented; appearance - appears appropriate for age, normoactive; attire - appropriately attired; nutritional status - well nourished; distress level - in no distress

Head and Face: normocephalic; atraumatic; normal hair and scalp; normal facial appearance

Eyes: extra-ocular movements intact; lids not swollen; no ptosis; conjunctiva, sclera and corneas clear; pupils equally reactive to light and accommodation, lenses without opacities

Neck: examination of the thyroid reveals a normal thyroid gland size and consistency

Respiratory: an assessment of respiratory effort reveals normal expansion and range of motion; normal respiratory effort, auscultation of the lungs revealed normal breath sounds bilaterally

Cardiovascular: normal sinus rhythm detected, auscultation of the heart revealed normal S1 and S2, no murmurs, gallops or rubs detected, examination of the carotid arteries revealed normal bilateral carotid pulses, normal upstroke, no bruits

Musculoskeletal: assymetrical gait, back - **paraspinal muscle tenderness, limited spinal flexion; limited spinal extension**

Psychiatric: oriented to person, place and time, **mood anxious,** normal speech and language

ASSESSMENT AND PLAN